STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 123213-001**

Blue Cross Blue Shield of Michigan
Respondent

_____

Issued and entered
this __12th___ day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On September 1, 2011, XXXXX, on behalf of her minor daughter XXXXX, filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on September 9, 2011.

The Petitioner is enrolled for health care benefits through a group plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on September 15, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is the *Flexible Blue Group Benefit Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner is a XX year-old girl who was born with Crouzon syndrome, a medical condition which required extensive surgery over several years. At issue in this appeal is coverage for a surgical procedure performed on August 19, 2009, at the XXXXX. BCBSM

denied coverage for the surgery, ruling that it was a dental procedure excluded from coverage under the Petitioner's benefit plan. The Petitioner's parents argue that the procedure was necessitated by their daughter's medical problems and should be covered since it was medically necessary. The amount in dispute for the surgery is $2,945.00.

BCBSM held a managerial-level conference and issued a final adverse determination dated July 19, 2011, affirming its denial of coverage.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's surgery of August 19, 2009?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination of July 19, 2011, issued to the Petitioner's mother, BCBSM explained its denial of coverage:

> . . . We are unable to allow payment for XXXXX's service because it does not meet the criteria for payment under your Blue Cross Blue Shield coverage.
>
> To clarify, you are covered under the *Flexible Blue Group Benefits Certificate*. As explained on page 4.23 under **Physician and Other Professional Provider Services That are Not Payable**:
>
> > Dental care except to treat accidental injuries or multiple extractions or removal of unerupted teeth, alveoplasty or gingivectomy when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition.
>
> The documentation provided by Dr. XXXXX indicates that on the date of services your daughter had placement of her fabricated denture. Certain maxillofacial prosthetic appliances (devices used to replace oral or maxillofacial anatomical efficiencies) may be covered, we do not allow benefits for any dental appliances.

Petitioner's Argument

In her letter of appeal to BCBSM, the Petitioner's mother wrote:

> This procedure was made necessary as the direct result of XXXXX's pre-existing MEDICAL condition, Crouzon Syndrome. In 2004, XXXXX underwent a surgical procedure . . . designed to move the entire mid-face forward to provide relief on

> the obstructive apnea and pressure on the brain that plagued XXXXX as the result of her condition. During that mid-face advancement complications caused blood flow to be cut off to one side of her face, which resulted in a large amount of bone loss. A procedure soon followed to remove dead bone, dead tissue and stabilize the area. As a direct result of this, XXXXX lost most of the left side of her face including her teeth and jaw. There have been several procedures that have followed since, including the surgery performed on August 19, 2009.
>
> We are struggling to understand how this procedure can possible be viewed as elective and not medically necessary when every single doctor that has been associated with her case insists that it is medically necessary. . . .

Commissioner's Review

The Petitioner's parents seek coverage from BCBSM for what the Petitioner's surgeon described as "a maxillofacial prosthetic procedure" performed on August 19, 2009. BCBSM's *Flexible Blue Group Benefits Certificate* primarily covers medical services; dental care is only covered in very limited circumstances such as emergency dental treatment. (See page 5.1 of the certificate.) The certificate, on page 4.23, excludes coverage for dental care and dental implants and related services. The certificate does provide coverage for a maxillofacial prosthesis which is defined on page 7.13 as:

> A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

This definition does not include the care sought for the Petitioner which involved surgery on implants in the Petitioner's upper jaw. The replacement of teeth or appliances to support teeth are excluded from coverage under the definition of "maxillofacial prosthesis" quoted above. While there is no question that the surgery was medically necessary, it is not a covered benefit under the *Flexible Blue* certificate. The Commissioner finds that BCBSM's denial of the prosthesis is consistent with the terms of the certificate.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of July 19, 2011, is upheld. BCBSM is not required to provide coverage for Petitioner's surgery of August 19, 2009.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner